* Acceptable POC *

DEPARTMENT OF HEALTH AND HUMAN SERVICES #2
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445259	A. BUILDING _____ B. WING _____	C 04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT VIEW OF LAKE CITY, LLC	204 INDUSTRIAL PARK RD LAKE CITY, TN 37769

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of the facility's Guidelines for	F 157	**1.** a. Resident #3's family was notified that there was a missing Fentanyl patch on 4/25/2012 by the Director of Nurses. An audit of the two residents that are currently using pain patches was completed on 4/17/2012 by the Director of Nursing. The audit was conducted to verify that no other current residents were affected by this deficient practice. The audit consisted of a retro 30 day review. There were no deficient practices identified during the audit. Revised Guidelines for Pain Patch Administration was implemented on April 17, 2012 by the Director of Nursing and the Administrator. The Fentanyl Patch Verification form was implemented in September 2011 by the Director of Nursing when the initial patches were found to be missing. Two nurses were required to sign off every hour to identify patch placement, as a result of the pain patches remaining in place since the original incident, the Fentanyl Patch Verification form was revised to reflect a q shift check while continuing to require two nurses to verify placement. b. A review was conducted on the residents that had falls from 3/20/2012 to 4/20/2012. There	4/25/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/25/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 Accidents and Incidents/Unusual Occurrences Investigating and Reporting, review of the facility investigation, review of hospital records and interview, the facility failed to notify the family of the missing Fentanyl (pain) patches for one (#3) and failed to notify the physician of a fall with injury for one (#5) of six residents reviewed. The findings included: Resident #3 was admitted to the facility on June 3, 2011, with diagnoses including Cerebral Vascular Accident (stroke), Dysphasia (speech impairment), and Osteoarthritis. Medical record review of the Minimum Data Set (MDS) dated October 10, 2011, revealed the resident had severe cognitive impairment, on a scheduled pain regimen, experienced pain occasionally, and rated pain moderate. Medical record review of the physician's recapitulation orders dated September 2011 revealed, "...Fentanyl 25 mcg (microgram) apply one patch topically and change every 72 hours check placement every shift..." Review of a facility investigation dated September 26, 2011, revealed on September 24, 2011, at 9:00 a.m., Licensed Practical Nurse (LPN) #3 reported to Registered Nurse (RN) Supervisor #1, the resident's pain patch was missing from the resident. Medical record review of the Medication Administration Record (MAR) dated September 1-30, 2011, revealed the pain patch was due to be changed September 24, 2011, at 9:00 a.m. Further review of the facility investigation revealed on September 24, 2011, at 7:30 p.m.,	F 157	were a total of 13 residents that were reviewed as a part of this audit. The audit was conducted by the Director of Nurses to identify any resident that did not have the physician or nurse practitioner notified. The results of the audit proved that there were no residents that the physician or the nurse practitioner was not notified. The Administrator and the Director of Nurses reviewed the Guidelines for Accidents and Incidents / Unusual Occurrences- Investigating and Reporting Policy, and The Guidelines for Pain Assessment Policy to ensure that the current policies effectively address how to notify medical personnel in the case of a fall with injury. There was Pain Screening Form, a Fall Decision Tree, and a Resident Assessment Tree that was created and added to the incident report to provide additional guidance to correctly complete incident reports. **2** a. An audit of the two residents that are currently using pain patches was completed on 4/17/2012 by the Director of Nursing. During the audit conducted by the Director of Nursing there were no patients identified that was affected by the deficient practice.	

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F 157	Continued From page 2 LPN # 5 observed the pain patch missing; notified the Nurse Practitioner (NP); and received an order to replace the patch. Continued review of the facility investigation dated September 26, 2011, revealed the resident had two pain patches missing-one on September 24, 2011, and one on September 25, 2011, and revealed the family was not notified of the missing Fentanyl Patches. Interview with the Director of Nursing (DON) on April 3, 2012, at 1:38 p.m., in the conference room, confirmed the facility failed to notify the family of the missing pain patches. Resident # 5 was admitted to the facility on June 29, 2010, with diagnoses including Alzheimer's Disease, Dysphagia, Iron Deficiency Anemia, Degenerative Joint Disease, Dementia, Hypertension, Depression, Chronic Pain, Allergic Rhinitis, history of Anxiety and Gait Disorder. Medical record review of the MDS dated October 13, 2011, revealed the resident had a fall with major injury since the prior MDS dated August 5, 2011. Medical record review of the restorative plan of treatment dated June 1-30, 2011, and July 1-31, 2011, revealed restorative staff ambulated the resident fifteen feet three times a week. Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #9 dated July 31, 2011, (6:00 a.m.-6:00 p.m., day shift) revealed, "...found in floor in seated position. Alarm	F 157	**b.** A review was conducted on the residents that had falls from 3/20/2012 to 4/20/2012.There was a total of 13 residents that were reviewed as a part of this audit. The audit was conducted by the Director of Nurses to identify any one that did not have the physician or nurse practitioner notified. The results of the audit proved that there were no residents identified that the physician or the nurse practitioner was not notified. **3.** a. The Director of Nursing and the Administrator created a revision of the Guidelines for Pain Patch Administration. The new guideline was implemented on April 17, 2012 to address notification of any medication changes and specifically addressed the removal of a patch. There was also a Fentanyl Patch Verification form that was created by the Director of Nursing and implemented in September 2011 when the initial patches were found to be missing. Two nurses were required to sign off every hour to identify patch placement, as a result of the pain patches remaining in place since the original incident we revised the Fentanyl Patch Verification form to reflect a q shift check while continuing to require two nurses	

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F 157	Continued From page 3 sounding...dressed in gown. No shoes or socks on...full range of motion all extremities. No s/s (signs or symptoms) discomfort appreciated...Unable to do orthopedic for resident (secondary) to res (resident) inability to stand. Will monitor closely..." Medical record review and review of the documentation (physician/Nurse Practitioner (NP) board for NP or physician notification dated July 31, 2011, revealed neither the NP nor the physician was notified of the fall. Medical record review of a nurse's note dated August 5, 2011, revealed NP #2 was notified to check the resident's right hip, leg, knee and foot. Medical record review of the NP note dated August 5, 2011, revealed, "...Nurses noted that patient's right leg seems to be rotated inward since a recent fall. They also said that she seems to have pain when the right leg is moved. She was found a few days ago on the floor beside her bed; nobody witnessed the fall...made a face and complained when the right hip and right knee were palpated...sits with the right leg rotated inward...has an area of ecchymosis with some edema on the plantar surface of the right foot...also complained when this area was palpated..." Review of a facility x-ray report dated August 5, 2011, revealed, "...acute femoral neck fracture...moderate osteoporosis..." Medical record review of a nurse's note dated August 5, 2011, at 10:15 p.m., revealed the resident was transported to the hospital.	F 157	to verify placement. All nursing staff was in-serviced by the Administrator and the Director of Nursing or designee. All clinical staff was in-serviced on The Guidelines for Pain Patch Administration Policy regarding a change in condition of a resident by 4/20/2012. b. There was a chart audit conducted by the Director of Nurses to identify any other resident that did not have the physician or nurse practitioner notified in the event of a fall. The results of the audit proved that there were no residents that the physician or the nurse practitioner was not notified. The Administrator and the Director of Nurses reviewed the Guidelines for Accidents and Incidents / Unusual Occurrences- Investigating and Reporting Policy, and The Guidelines for Pain Assessment Policy to ensure that the current policies effectively address how to notify medical personnel in the case of a fall with injury. There was Pain Screening Form, a Fall Decision Tree, and a Resident Assessment Tree that was created and added to the incident report to provide additional guidance to correctly complete incident reports. These tools all address how to	

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F 157	Continued From page 4 Review of a hospital operative report dated August 6, 2011, revealed, "...Right total hip arthroplasty...82-year-old...with Dementia who fell at the nursing home onto...right hip...had persistent pain and reluctance to bear weight on the leg...was eventually brought to the emergency department, where x-rays demonstrated the presence of a subacute displaced femoral neck fracture..." Medical record review of a nurse's note dated August 10, 2011, revealed the resident returned to the facility on August 10, 2011. Review of the facility's policy for physician notification revealed, "...The facility will notify Physician...of an (a) change in status in (a) timely manner. 1.) All incidents with/without injuries/change in resident condition will be reported to MD (Medical Doctor)/NP...2.) Any incident, which there is no injury noted upon assessment, which occurs after hours may be place(d) on NP board for notification, (At) any time a significant change is noted, notification will result immediately...3.) Any incident which injury is noted, the NP/MD...will be notified immediately." Review of the facility's "Guidelines for Accidents and Incidents/Unusual Occurrences Investigating and Reporting" revealed, "...The following data, as applicable, shall be included on the Accident/Incident Investigation Report; Resident Abuse Investigation Report; or the Post Fall Assessment/Investigation Report Form:...The time the injured person's Attending Physician was notified, as well as the time the physician	F 157	correctly notify a physician or nurse practitioner in the event of a fall. **4.** The Director of Nursing or designee will be assigned to audit the Fentanyl Patch Verification forms once a week for three months to identify if families are being notified in the case of a missing pain patch. The Director of Nursing or designee will also be assigned to audit the incident reports once a week for three months to identify any fall in which the physician or the nurse practitioner are not informed according to the Accidents and Incidents / Unusual Occurrences- Investigating and Reporting Policy.	

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F 157	Continued From page 5 responded and his or her instructions..." Interview on April 2, 2012, at 1:10 p.m., in the conference room, with the Director of Nursing (DON) confirmed LPN #9 failed to notify the physician or the NP of the fall on July 31, 2011. Interview on April 3, 2012, at 10:50 a.m., with the DON confirmed LPN #9 "lied" about placing the resident "on the board" to notify the NP of the fall and confirmed LPN #9 was terminated after failure to notify the physician and the oncoming nurse of the fall (as well as failure to accurately assess the resident after the fall).	F 157		
F 224 SS=D	C/O #29506 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, review of facility investigation, and interview, the facility failed to prevent the misappropriation of pain medications for three residents (#1, #2, and #3) of six residents reviewed. The findings included:	F 224	**1.** Residents #1, 2, and 3 were all reimbursed for the property that was unable to be recovered by 4/10/2012. An audit of the two residents that are currently using pain patches was completed by 4/17/2012 by the Director of Nursing. The audit was conducted to verify that no other current residents were affected by this deficient practice. The audit consisted of a retro 30 day review. There were no deficient practices identified during the audit. Revised Guidelines for Pain Patch Administration was implemented on April 17, 2012 by the Director of Nursing and the Administrator. The Fentanyl Patch Verification form was implemented in September 2011	4/25/12

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F 224	Continued From page 6 Resident #1 was readmitted to the facility on October 16, 2008, with diagnoses including Dementia, Depression and Osteoarthritis. Medical record review of the Minimum Data Set (MDS) dated September 16, 2011, revealed "...Pain Intensity...on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine..." Further review of the MDS revealed the resident responded "eight". Medical record review of the physician's recapitulation orders dated September 1-30, 2011, revealed, "...Fentanyl 50 (pain) mcg (micrograms) 1 patch topically and change every 72 hours. Check placement every shift..." Medical record review of a progress note dated September 2, 2011, revealed "...DON (Director of Nursing) notified (Nurse Practitioner #1) that Fentanyl patch was missing (from the resident)...facility pharmacist notified...discussed discontinuation of patch...patch was D/C (discontinued)...changed to MS (morphine sulfate) ER (extended release) 60 mg (milligram) po (per mouth) Bid (twice daily)..." Resident #2 was admitted to the facility on July 5, 2010, and readmitted on October 3, 2011, with diagnoses including Congestive Heart Failure, Dysphasia (speech impairment), Anxiety and Chronic Back Pain. Medical record review of the MDS dated January 2, 2012, revealed the resident was cognitively intact, experienced pain occasionally and pain was rated a five when ask, on a zero to ten scale with zero being no pain and ten as the worst pain	F 224	by the Director of Nursing when the initial patches were found to be missing. Two nurses were required to sign off every hour to identify patch placement, as a result of the pain patches remaining in place since the original incident, the Fentanyl Patch Verification form was revised to reflect a q shift check while continuing to require two nurses to verify placement. **2.** An audit of the two residents that are currently using pain patches was completed on 4/17/2012 by the Director of Nursing. During the audit conducted by the Director of Nursing there were no patients identified that was affected by the deficient practice **3.** The Director of Nursing and the Administrator created a revision of the Guidelines for Pain Patch Administration. The new guideline was implemented on April 17, 2012 to address notification of any medication changes and specifically addressed the removal of a patch. There was also a Fentanyl Patch Verification form that was created by the Director of Nursing and implemented in September 2011 when the initial patches were found to be missing. Two nurses were required to sign off every hour to identify patch placement, as	

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F 224	Continued From page 7 one could imagine. Medical record review of the physician's recapitulation orders dated September 1-30, 2011, revealed, "...Fentanyl 25 mcg apply 1 patch topically w/ (with) 12 mcg=37 mcg change every 72 hours check placement each shift..." Review of a facility investigation (undated) revealed on September 24, 2011, at 9:00 a.m., Licensed Practical Nurse (LPN) #4 started to replace the Fentanyl patch, and the patch, which was placed on the resident on September 21, 2011, could not be located on the resident or in the resident's bed. LPN #4 reported the missing patch to the Registered Nurse (RN) Supervisor #1. Resident #3 was admitted to the facility on June 3, 2011, with diagnoses including Cerebral Vascular Accident (stroke), Dysphasia (speech impairment) and Osteoarthritis. Medical record review of the MDS dated October 10, 2011, revealed the resident had severe cognitive impairment, on a scheduled pain regimen, experienced pain occasionally, and rated pain moderate. Medical record review of the physician's recapitulation orders dated September 1-30, 2011, revealed, "...Fentanyl 25 mcg apply one patch topically and change every 72 hours check placement every shift..." Review of the facility investigation dated September 26, 2011, revealed on September 24, 2011, at 9:00 a.m., LPN #3 reported to RN	F 224	a result of the pain patches remaining in place since the original incident we revised the Fentanyl Patch Verification form to reflect a q shift check on 4/18/2012 while continuing to require two nurses to verify placement. All nursing staff was in-serviced by the Administrator and the Director of Nursing or designee by 4/20/2012. All in-services for The Guidelines for Pain Patch Administration Policy regarding the identification and placement of a pain patch were completed by 4/20/2012. **4.** The Director of Nursing or designee will be assigned to audit the Fentanyl Patch Verification forms once a week for three months. This audit will be conducted to identify compliance with the Fentanyl Patch Verification policy and procedure. The Director of Nursing will also review the Accidents and Incidents / Unusual Occurrences-Investigating and Reporting log once a week for three months and they will be reviewed in the monthly Quality Assurance Meeting for three months to ensure compliance with family and medical staff notification. The review of these reports will be used to verify accuracy and	

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F 224	Continued From page 8 Supervisor #1 the resident's pain patch was missing from the resident when checked. Medical record review of the Medication Administration Record (MAR) dated September 1-30, 2011, revealed the pain patch was due to be changed September 24, 2011, at 9:00 a.m. Further review of the facility investigation revealed on September 24, 2011, at 7:30 p.m., LPN # 5 observed the pain patch missing; notified the Nurse Practitioner; and received an order to replace the patch. Interview with the Administrator and the DON on April 2, 2012, at 10:00 a.m., in the conference room, confirmed the facility failed to prevent the misappropriation of pain medications for three residents (#1, #2 and #3). Telephone interview on April 10, 2012, at 10:45 a.m., with the Administrator confirmed the replacement charges for the missing pain patches for residents #1 and #3 were billed to Medicare Part D, and the two residents were charged a twenty percent co-pay. Continued interview confirmed the replacment charge for the missing patch for resident #2 was billed to Medicare Part D, and the resident was not billed for a co-pay. Continued interview with the Administrator revealed the Administrator had discussed the charges to insurance and the residents with the pharmacy, and the pharmacy was adjusting the credit "today." C/O #29506	F 224	to ensure the resident's property is protected.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225	**1.** Residents #1, 2, and 3 were all reimbursed for the property that was unable to be recovered by 4/10/2012. The state survey team identified that residents	4/25/12

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F 225	Continued From page 9 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225	#1, 2, and 3 were affected by this deficient practice. 4 residents were reviewed during an audit that spanned from 3/20/2012 to 4/20/2012 that reviewed the concern and complement logs as well as the missing item form by the Administrator on 4/20/2012 This audit was conducted to identify anyone else that may be affected by the deficient practice. There was an investigation that was conducted by the Administrator and the Director of Nursing on the pain patch that was missing for resident #3. The Administrator and the Director of Nursing created and implemented The Guidelines for Pain Patch Administration Policy to address that standard procedures, Fentanyl patch monitoring, and the discontinuation of fentanyl patches. All nursing staff was in-serviced on The Guidelines for Pain Patch Administration Policy by the Director of Nursing, the Administrator or designee by 4/20/12. There were no other residents found to be affected by this deficient practice. **2.** An audit of the two residents that are currently using pain patches was completed on 4/17/2012 by the Director of Nursing. During the audit	

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F 225	Continued From page 10 Based on medical record review, review of facility policy, review of the facility investigation and interview, the facility failed to notify the State Department of Health and Local Law Enforcement of the misappropriation of Fentanyl (pain) patches for three residents (#1, #2, and #3) and failed to fully investigate the misappropriation of one pain patch for one (#3) of six residents reviewed. The findings included: Resident #1 was readmitted to the facility on October 16, 2008, with diagnoses including Dementia, Depression and Osteoarthritis. Medical record review of the Minimum Data Set (MDS) dated September 16, 2011, revealed "...Pain Intensity...on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine..." Further review of the MDS revealed the resident responded eight. Medical record review of the physician's recapitulation orders dated September 1-30, 2011, revealed, "...Fentanyl (pain) 50 mcg (micrograms) 1 patch topically and change every 72 hours. Check placement every shift..." Medical record review of a progress note dated September 2, 2011, revealed "...DON (Director of Nursing) notified (Nurse Practitioner #1) that Fentanyl patch was missing...facility pharmacist notified...discussed discontinuation of patch...patch was D/C (discontinued)...changed to MS (morphine sulfate) ER (extended release) 60 mg (milligram) po (per mouth) Bid (twice daily)..."	F 225	conducted by the Director of Nursing there were no patients identified that was affected by the deficient practice. Four residents were reviewed during an audit that spanned from 3/20/2012 to 4/20/2012 that reviewed the concern and complement logs as well as the missing item form by the Administrator on 4/20/2012. The logs were reviewed to identify any residents that were missing property and the items were not returned to them. There were no other residents found to be affected by this deficient practice. **3.** All staff was in-serviced on the Elder Justice Act, and the clinical staff was in-serviced on the policy associated with the Pain Patch Administration Guidelines. All the in-services were conducted by the Administrator, the Director of Nursing and designee by 4/20/2012. The focus of the in-service was misappropriation of resident property and how to properly report misappropriation through the missing items form, the concern and complements logs, and the interpretation of the Elder Justice Act. The State reporting guidelines were reviewed by the Administrator and the Director of Nursing for clarification of reporting	

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F 225	Continued From page 11 Resident #2 was admitted to the facility on July 5, 2010, and readmitted on October 3, 2011, with diagnoses including Congestive Heart Failure, Dysphasia, Anxiety and Chronic Back Pain. Medical record review of the MDS dated January 2, 2012, revealed the resident was cognitively intact, experienced pain occasionally and pain was rated a five when ask, on a zero to ten scale with zero being no pain and ten as the worst pain one could imagine. Medical record review of the physician's recapitulation orders dated September 1-30, 2011, revealed, "...Fentanyl 25 mcg apply 1 patch topically w/ (with) 12 mcg=37 mcg change every 72 hours check placement each shift..." Review of a facility investigation dated September 26, 2011, revealed on September 24, 2011, at 9:00 a.m., Licensed Practical Nurse (LPN) #4 started to apply a new Fentanyl patch on the resident, and the patch, which had been placed on the resident on September 21, 2011, could not be located on the resident or in the resident's bed. LPN #4 reported the missing patch to the Registered Nurse (RN) Supervisor #1. Resident #3 was admitted to the facility on June 3, 2011, with diagnoses including Cerebral Vascular Accident (stroke), Dysphasia (speech impairment) and Osteoarthritis. Medical record review of the MDS dated October 10, 2011, revealed the resident had severe cognitive impairment, was on a scheduled pain regimen and experienced pain occasionally and	F 225	responsibilities on 4/18/2012. The Director of Nursing and the Administrator created a revision of the Guidelines for Pain Patch Administration. The new guidelines were implemented on April 17, 2012 to address notification of any medication changes and specifically addressed the removal of a patch. The Administrator and the Director of Nurses reviewed the Guidelines for Accidents and Incidents / Unusual Occurrences- Investigating and Reporting Policy, and The Guidelines for Pain Assessment Policy to ensure that the current policies effectively addressed how to notify medical personnel in the case of the discovery of a missing fentanyl patch. **4.** The Administrator, the Director of Nursing, or designee will review the concern and complement logs, the missing items report, and the pain screening form weekly for three months for the residents that have fentanyl patches. These forms will be reviewed for accuracy to ensure compliance with the required reporting guideline referenced in the Elder Justice. These findings will be reviewed in the Monthly Quality Assurance Meetings for three months.	

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F 225	Continued From page 12 rated the pain as moderate. Medical record review of the physician recapitulation orders dated September 1-30, 2011, revealed, "...Fentanyl 25 mcg apply one patch topically and change every 72 hours check placement every shift..." Review of the facility investigation dated September 26, 2011, revealed on September 24, 2011, at 9:00 a.m., LPN #3 reported to RN Supervisor #1 the resident's pain patch was missing from the resident. Medical record review of the Medication Administration Record (MAR) dated September 1-30, 2011, revealed the pain patch was due to be changed September 24, 2011, at 9:00 a.m. Further review of the facility investigation revealed on September 24, 2011, at 7:30 p.m., LPN # 5 found the pain patch missing; notified the Nurse Practitioner; and received a new order to replace the patch. Review of facility policy, Policy and Procedure Relative To Notification Of Employees And Other Covered Individual's Obligation To Report suspected Crimes Under The Elder Justice Act no date revealed "...report the reasonable suspicion of a crime committed against a resident...to the state survey agency...Lake City Police Department..." Review of the facility "Employee Notice" policy (no date) revealed "...Covered individual is an owner, operator, employee...manager...covered individuals...must notify both State Survey Agency...local law enforcement...within 24 hours..."	F 225		

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F 225	Continued From page 13 Interview with the Administrator and the DON on April 2, 2012, at 10:00 a.m., in the Conference Room, confirmed the facility failed to notify the State Agency and Local Law Enforcement of the missing Fentanyl patches for three residents (#1, #2 and #3). Interview with the DON on April 3, 2012, at 1:30 p.m., in the conference room, confirmed the facility failed to investigate and the DON had no knowledge of the missing pain patch for resident #3 on September 25, 2012, at 7:35 p.m. C/O #29506	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy and interview the facility failed to follow the physician's order for one resident (#4) of six residents reviewed. The findings included: Resident #4 was admitted to the facility on January 6, 2012, and readmitted on February 27, 2012, with diagnoses including Vascular Dementia, Anxiety and Depressive Disorder. Medical record review of the Minimum Data Set (MDS) dated February 8, 2012, revealed the resident had severe cognitive impairment, had	F 281	**1.** Resident #4's Medication Administration Records was reviewed for accuracy on 4/18/2012 by the Director of Nursing. There was no other missed dose of medication that was discovered as of 4/20/2012. A chart review was conducted on 3 of the patients that received IM injections for increased agitation in the last 30 days. During the investigation no other residents were found to be affected by this deficient practice. **2.** An audit was conducted on 4/18/12 and completed on 4/20/2012 on the current physician orders related to psychiatric IM medications to identify anyone else that may be affected by this deficient practice. A chart review was	4/25/12

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F 281	Continued From page 14 inattention, disorganized thinking, an altered level of consciousness continuously and delusions. Medical record review of the care plan dated February 27, 2012, revealed "...Alzheimer's dementia with aggressive behaviors...physical and verbal behaviors..." Medical record review of a physician's telephone order dated February 2, 2012, at 10:00 p.m., revealed "...5 mg (milligram) Geodon (antipsychotic) Inj (injection) now..." for extreme agitation. Medical record review of the Medication Administration Record (MAR dated February 1-19, 2012, revealed no documentation Geodon 5 mg was administered on February 2, 2012. Review of the facility policy "Administering Medication Guidelines" revised April 2008, revealed "...medications must be administered in a timely manner and in accordance with the attending physician's written/verbal orders..." Interview with the Director of Nursing on April 2, 2012, at 1:00 p.m., in the Conference Room, confirmed Geodon 5 mg was not administered on February 2, 2012, as ordered by the physician. C/O #29506	F 281	conducted on 3 of the patients that received IM injections for increased agitation in the last 30 days. During the investigation no other residents were found to be affected by this deficient practice. **3.** All clinical staff was in-serviced by the Administrator, the Director of Nursing, or designee on the policy regarding following physician's orders by 4/20/2012. The Administrator and the Director of Nursing reviewed the Administrating Medication Guidelines policy on 4/18/2012 to ensure the policy accurately reflected following MD orders for medication administration orders. **4.** Physician's orders will be reviewed in the morning Quality Assurance meetings for three months. The unit mangers will ensure that current orders are executed properly, by reviewing the orders in the morning Quality Assurance Meeting. Two nurses will be required to sign off on the orders and the unit managers will be responsible for ensuring that the orders are properly executed. The finding will be reviewed in the Monthly Quality Assurance meeting for three months by the Administrator, the Director of Nursing, or designee.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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F 309	Continued From page 15 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of hospital records, review of the facility investigation, review of facility policy, observation and interview the facility failed to assess the impact of a fall for one resident (#5) resulting in a delay in treatment and a delay in the administration of pain medication and failed to ensure physician's orders were followed for the administration of narcotic pain medication (Fentanyl patch) for one (#2) of six residents reviewed. The facility's failure resulted in harm for residents #5 and #2. Resident #5 was admitted to the facility on June 29, 2010, with diagnoses including Alzheimer's Disease, Dysphagia, Iron Deficiency Anemia, Degenerative Joint Disease, Dementia, Hypertension, Depression, Chronic Pain, Allergic Rhinitis, history of Anxiety and Gait Disorder. Medical record review of the Minimum Data Set (MDS) dated May 13, 2011, revealed the resident had no difficulty focusing attention and no disorganized thinking; required extensive assistance with activities of daily living including transfers and ambulation and had no limitation in range of motion. Medical record review of the MDS dated October 13, 2011, revealed the resident had difficulty focusing attention and disorganized thinking; was	F 309	**1.** a. Resident #5's chart was reviewed on 4/18/2012 by the Director of Nursing to ensure that there were no other delays in treatment. A review was conducted on the residents that had falls from 3/20/2012 to 4/20/2012. There were a total of 13 residents that were reviewed as a part of this audit. The audit was conducted by the Director of Nurses to identify any resident that did not have the physician or nurse practitioner notified. The results of the audit proved that there were no residents that the physician or the nurse practitioner was not notified. The Administrator and the Director of Nurses reviewed the Guidelines for Accidents and Incidents / Unusual Occurrences- Investigating and Reporting Policy, and The Guidelines for Pain Assessment Policy to ensure that the current policies effectively address how to notify medical personnel in the case of a fall with injury on 4/18/2012. There was a Pain Screening Form, a Fall Decision Tree, and a Resident Assessment Tree that was created and added to the incident report to provide additional guidance to correctly and more accurately complete	4/25/12

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F 309	Continued From page 16 not ambulatory; had impairment in functional range of motion in the lower extremity; and had a fall with major injury since the most recent MDS dated August 5, 2011. Medical record review of the restorative plan of treatment dated June 1-30, 2011, and July 1-31, 2011, revealed the restorative staff ambulated the resident fifteen feet three times a week. Medical record review of a pain assessment dated July 29, 2011, revealed the resident denied having pain. Medical record review of the physician's recapitulation orders dated July 1-31, 2011, and the Medication Administration Record (MAR) dated July 1-31, 2011, revealed the resident received no pain medications. Medical record review of a day shift (6:00 a.m. -6:00 p.m.) nurse's note by Licensed Practical Nurse (LPN) #9 dated July 31, 2011, revealed, "...found in floor in seated position. Alarm sounding...dressed in gown. No shoes or socks on...full range of motion all extremities. No s/s (signs or symptoms) discomfort appreciated...Unable to do orthopedic for resident (secondary) to res (resident) inability to stand. Will monitor closely..." Medical record review of nurses' notes dated July 31-August 2, 2011, revealed no documentation the resident's condition, vital signs or pain was assessed on night shift (6:00 p.m.-6:00 a.m.) July 31-August 1, 2011 or on August 3, 2011. Medical record review of a nurse's note dated	F 309	incident reports. All clinical staff was in-serviced by the Administrator, the Director of Nursing or designee on the policy regarding following physician's orders by 4/20/2012. The Administrator and the Director of Nursing reviewed the Administrating Medication Guidelines policy on 4/18/2012 to ensure the policy accurately reflected following MD orders for medication administration orders. **b.** Resident #2 orders are now being followed. The Director of Nursing performed a chart review of the past 30 days to ensure that resident #2's orders were being followed on 4/17/2012. An audit of the two residents that are currently using pain patches was completed on 4/17/2012 by the Director of Nursing. The audit was conducted to verify that no other current residents were affected by this deficient practice. The audit consisted of a retro 30 day review. There were no deficient practices identified during the audit. Revised Guidelines for Pain Patch Administration was implemented on April 17, 2012 by the Director of Nursing and the Administrator. The Fentanyl Patch Verification form was implemented in September 2011	

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F 309	Continued From page 17 August 5, 2011, revealed the Nurse Practitioner (NP) was asked to check the resident's right hip, leg, knee and foot. Medical record review of the (NP) note dated August 5, 2011, revealed, "...Nurses noted that patient's right leg seems to be rotated inward since a recent fall. They also said that she seems to have pain when the right leg is moved. She was found a few days ago on the floor beside her bed; nobody witnessed the fall...made a face and complained when the right hip and right knee were palpated...sits with the right leg rotated inward...has an area of ecchymosis with some edema on the plantar surface of the right foot...also complained when this area was palpated..." Review of a facility x-ray report dated August 5, 2011, revealed, "...acute femoral neck fracture...moderate osteoporosis..." Medical record review of a nurse's note dated August 5, 2011, at 10:15 p.m., revealed the resident was transported to the hospital. Review of a hospital history and physical dated August 6, 2011, revealed, "...Apparently, the patient fell Sunday (July 31, 2011)...Right hip fracture status post fall 6 days ago..." Review of a hospital x-ray report dated August 6, 2011, revealed, "...complete fracture through the right femoral neck in the subcapital region...cephalad (anterior) displacement of the distal fracture fragment. Valgus (outward) angulation at the fracture site..."	F 309	by the Director of Nursing when the initial patches were found to be missing. Two nurses were required to sign off every hour to identify patch placement, as a result of the pain patches remaining in place since the original incident, the Fentanyl Patch Verification form was revised to reflect a q shift check while continuing to require two nurses to verify placement. **2.** a. An audit of the incident reports that included falls was reviewed for the last 30 days on 4/18/2012 to ensure that other residents with incidents reports were assessed properly and were not affected by this deficient practice. A review was conducted on the residents that had falls from 3/20/2012 to 4/20/2012. There were a total of 13 residents that were reviewed as a part of this audit. The audit was conducted by the Director of Nurses to identify any resident that did not have the physician or nurse practitioner notified. The results of the audit proved that there were no residents that the physician or the nurse practitioner was not notified. The Administrator and the Director of Nurses reviewed the Guidelines for Accidents and Incidents / Unusual Occurrences- Investigating and	

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F 309	Continued From page 18 Review of a hospital operative report dated August 6, 2011, revealed, "...Right total hip arthroplasty...82-year-old...with Dementia who fell at the nursing home onto...right hip...had persistent pain and reluctance to bear weight on the leg...was eventually brought to the emergency department, where x-rays demonstrated the presence of a subacute displaced femoral neck fracture..." Medical record review of a nurse's note revealed the resident returned to the facility on August 10, 2011. Medical record review of the MAR dated August 10-31, 2011, revealed Lortab (narcotic pain medication) 5/325 mg (milligrams) 1-2 tablets every 4-6 hours as needed for pain was administered on August 11, 2011; Lortab 5/500 mg was administered twice daily from August 1-5, 2011; and Lortab 5/500 mg was administered every six hours from August 6-27. 2011. Review of the facility policy (guidelines) for managing falls revealed, "...If a fall occurs, the licensed staff assesses for injury and then investigates the cause using a Post Fall Assessment/Investigation Report Form...Post fall documentation will include vital signs and assessment every shift for 72 hours..." Interview on April 2, 2012, at 1:10 p.m., in the conference room, with the Director of Nursing (DON) revealed LPN #9 was terminated after the fall on July 31, 2011, because LPN #9 failed to assess the resident for any signs of injury after the fall; failed to complete an Incident Report; failed to notify the oncoming shift of the fall; and	F 309	Reporting Policy, and The Guidelines for Pain Assessment Policy to ensure that the current policies effectively address how to notify medical personnel in the case of a fall with injury. There was Pain Screening Form, a Fall Decision Tree, and a Resident Assessment Tree that was created and added to the incident report to provide additional guidance to correctly and more accurately complete incident reports. **b.** An audit was conducted on 100% of the residents that utilize pain patches on 4/18/2012 to identify any other residents that could be affected by this deficient practice. An audit of the two residents that are currently using pain patches was completed on 4/17/2012 by the Director of Nursing. As a result of the audit there were no others identified to be affected by this deficient practice. **3.** All nursing staff was in-serviced on the proper execution of the Guidelines for Accidents and Incidents / Unusual Occurrences-Investigating and Reporting Policy by the Administrator, the Director of Nursing or designee by 4/20/2012. They were also in-serviced on how to properly assess a resident fall when an impact is identified. All clinical	

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F 309	Continued From page 19 failed to include the fall on the 24 hour nursing report. Continued interview with the DON confirmed the resident "suffered harm from the fall," and LPN #9 failed to document appropriately and failed to make proper notifications after the fall. Continued interview confirmed the resident had no falls between July 31, 2011, and August 5, 2011, when the resident was assessed with the fractured hip. Review of the hospital x-ray report dated August 6, 2011, and interview on April 3, 2012, at 9:00 a.m., in the conference room with the NP confirmed the resident would have been in "extreme pain" with turning, repositioning and transfers after the fall on July 31, 2011, which resulted in the fractured hip. Continued interview confirmed if the resident was unable to verbally communicate pain due to Dementia, the resident would have had nonverbal signs of pain including grimacing. Continued interview with the NP confirmed the resident would have had an "immediate anteversion (internal rotation) of the hip" following the fracture. Interview on April 3, 2012, at 10:20 a.m., in the conference room with Registered Nurse (RN) Supervisor #3 and RN Supervisor #4 confirmed residents who fell were assessed every shift for pain or signs of injury for seventy-two hours after the fall. Medical record review and interview on April 3, 2012, at 10:50 a.m., in the conference room with the DON confirmed the resident was not assessed for pain or signs of injury for seventy-two hours after the fall on July 31, 2011, as required by facility policy. Continued interview	F 309	staff will be in-serviced on the amendments to the original Fentanyl Patch Administration Procedure by the above stated as well. Two nurses will be required to verify the placement of the pain patches by way of signature, and they will be required to verify the presence of the patch q shift with the relieving administering nurse. These verifications will be kept on a form designed to designate the existence of the patch, medication effectiveness, and the location to ensure the patch is readily identifiable. **4.** 95% of all Incident Reports and Physician's orders will be reviewed in the morning Quality Assurance meetings going forward to ensure compliance is being met. The unit mangers will ensure the orders are executed properly, as a part of their daily duties. The results will be reviewed in the Monthly Quality Assurance meeting for three months by the Administrator, the Director of Nursing, or designee for compliance. Compliance will be measured by the proper notification of medical personnel in the event that a fall is identified to avoid a delay in treatment, and that physician orders are being properly	

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F 309	Continued From page 20 confirmed LPN #9 "could not have assessed" the resident accurately after the fall on July 31, 2011, and "That's why (LPN #9) was terminated." Resident #2 was admitted to the facility on July 5, 2010, and readmitted on October 3, 2011, with diagnoses including Congestive Heart Failure, Dysphasia, Anxiety and Chronic Back Pain. Medical record review of the MDS dated January 2, 2012, revealed the resident was cognitively intact, experienced pain occasionally and pain was rated a five when ask, on a zero to ten scale with zero being no pain and ten as the worst pain one could imagine. Medical record review of the physician's recapitulation orders dated September 1-30, 2011, revealed "...Fentanyl (pain) 25 mcg (microgram) apply 1 patch topically w/ (with) 12 mcg=37 mcg change every 72 hours check placement each shift..." Medical record review of a physician's telephone order dated September 26, 2011, revealed "...D/C (discontinue) Fentanyl 12 mcg and 25 mcg...Morphine ER (Extended Release) 60 mg (milligram) bid (twice daily)..." Medical record review of a nurse's note dated September 27, 2011, at 9:20 p.m., revealed, "...Held Morphine on 8 pm med pass...very lethargic...could not sit up. Administered all other 8 pm meds...had to be reinforced x (tmes) 5 to open mouth and sip water...slurred speech...very disoriented...observed to be jerking on (right) side	F 309	followed to prevent future harm to other residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445259	A. BUILDING _____ B. WING _____	C 04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT VIEW OF LAKE CITY, LLC	204 INDUSTRIAL PARK RD LAKE CITY, TN 37769

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 21 of body. Attempted to obtain pulse rate...could not obtain for pt. (patient) jerking arms..." Medical record review of a nurse's note dated September 27, 2011, at 9:35 p.m., revealed, "placed call to NP & (and) notified of vs (vital signs)...B/P (blood pressure) 96/46...NP wanted Narcan (reverses effects of Morphine) 0.4 ml (milliliter) given..." Medical record review of a nurse's note dated September 27, 2011, at 9:45 p.m., revealed "0.4 ml Narcan administered IM (Intramuscular)...no response to Narcan...called NP back and informed of...response. NP then advised to go ahead and proceed w/ (with) sending pt to ER (emergency room)..." Review of a facility medication error investigation dated September 28, 2011, revealed on September 26, 2011, LPN #5 administered Morphine ER 60 mg and failed to remove the Fentanyl patches. Continued review revealed the resident was "...slow to respond, slurred speech"...and was transported to the hospital for evaluation. Review of a hospital discharge summary dated October 3, 2011, revealed, "...transferred to our facility because of bradycardia and hypotension...recently started on MS Contin and was thought possibly to have an overdose..given Narcan at the nursing home and her vital signs improved...came to our ER and initially blood pressure was 140/59...however, after some time in the ER, her heart rate blood pressure bottomed out again. Her heart rate went down to the 30s and blood pressure ws in the 60s or 70s...given	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 22 another dose of Narcan...improved again and once again about 2-3 hours later...vital signs dropped again...started on a Narcan drip at that time...spoke with the nursing home and apparently health wise the patients have been taken off the fentanyl patches for safety reasons...did respond to the Narcan drip and over the next 24 hours was able to be taken off of the drip..." Medical record review of a nurse's note dated October 3, 2011, at 8:00 p.m., revealed the resident returned to the facility by way of ambulance. Interview with the DON on April 3, 2012, at 1:05 p.m., in the conference room, confirmed the Fentanyl patch was not removed as ordered by the physician on September 26, 2011, prior to the administration of Morphine; the resident was transferred to the hospital and the facility's policy for pain medication was not followed. C/O #29506	F 309		